

City School District of New Rochelle - Annual Athletic Health History

To Be Completed and Signed By Parent/Guardian

Student Name:	DOB:	Date:
School:	Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Age:
Sport:	Level (check): <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	

General Health Concerns	Yes	No
1. Ever been restricted from sports by a doctor?		
2. Has an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Other		
3. Currently takes medications?		
4. Ever had surgery?		
5. Ever spent the night in a hospital?		
6. Mononucleosis within the last month?		
7. Have only one functioning kidney?		
8. Have a bleeding disorder?		
9. Have problems hearing or wears hearing aid(s)?		
10. Has vision problems/vision in only one eye?		
11. Wear glasses or contacts?		
Allergies	Yes	No
12. Has a life threatening allergy? Check applicable: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
13. Carries an epinephrine auto-injector?		
Breathing (Respiratory) Health	Yes	No
14. Ever complained of getting more tired or short of breath than peers during exercise?		
15. Wheeze or cough frequently during or after exercise?		
16. Ever diagnosed with asthma?		
17. Use or carry an inhaler or nebulizer?		
Females Only	Yes	No
18. Ever had a menstrual period?		
19. Has regular periods?		
20. Age periods began:		
21. Date of last menstrual period (LMP):		
Males Only	Yes	No
22. Has only one testicle?		
23. Has groin pain, a bulge, or hernia in the groin?		
Devices/Accommodations (*special form needed)	Yes	No
24. Uses a brace, orthotic, or other device?		
25. Has an insulin pump, glucose sensor, ostomy?	*	
26. Wears protective eyewear/goggles/face shield?		

Concussion/Head Injury History	Yes	No
27. Ever had a head injury or Concussion?		
28. Ever had a hit to the head/body causing headache, dizziness, nausea, confusion?		
29. Ever had headaches with exercise?		
30. Ever had any unexplained seizures?		
31. Currently treated for seizures or epilepsy?		
Heart Health	Yes	No
32. Ever passed out during or after exercise?		
33. Ever complained of light headedness or dizziness during or after exercise?		
34. Ever complained of chest pain, tightness or pressure during or after exercise?		
35. Ever complained of chest fluttering, skipped beats, heart racing, or has a pacemaker?		
36. Ever had a heart test done by a medical provider (EKG, echocardiogram, stress test)?		
37. Ever been diagnosed with a heart condition: <input type="checkbox"/> Heart Infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other:		
Injury History	Yes	No
38. Ever diagnosed with a stress fracture?		
39. Ever been unable to move arms/legs or had tingling, numbness or weakness after being hit or falling?		
40. Ever missed a practice or game due to a joint injury, pain or swelling?		
41. Has a bothersome bone, muscle or joint?		
42. Has joint pain, swelling, warmth or redness with use/activity?		
Skin Health	Yes	No
43. Currently has skin rashes, sores, or ulcers?		
44. Has had a herpes or MRSA skin infection?		
Stomach Health	Yes	No
45. Ever become ill exercising in hot weather?		
46. Has a special diet or avoids certain foods?		
47. Worries about own weight?		
48. Has stomach problems?		
49. Ever had an eating disorder?		

Family Heart History: Any relative with a murmur, hypertrophic or right ventricular cardiomyopathy, Marfan or Brugada Syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia?	Yes	No
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Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Provide a **Medication Administration Form** for any medication to be taken during practice or events